**CLINIC INFORMATION & MEDICAL HISTORY**

**In order to provide you with the most appropriate cosmetic treatment, we need to complete the following questionnaire. All information is strictly confidential.**

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PERSONAL HISTORY**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M F NB

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number for appointment/reminder/messages: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name and Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

Are you currently under the care of a physician? **Yes No** If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is your Primary M.D.? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supplements/Vitamins/OTC? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What medication(s) are you currently taking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you suffer from any of the following: (please circle)**

Diabetes Thyroid Condition Frequent Headaches Osteoporosis Back Pain Disk Herniation

High Blood Pressure Epilepsy/Seizures Joint swelling Varicose Veins Arthritis Cancer HIV

Contagious diseases Numbness or stabbing pains Cardiac or circulatory problems Auto immune disease

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a pacemaker implant/ defibrillator? **Yes No** Do you have a history of Keloid scarring? **Yes No**

Have you ever had surgery? **Yes No** If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any known drug/skin/other allergies? **Yes No** If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to egg or egg products? **Yes No** Are you allergic to bee stings? **Yes No**

Have you ever had a reaction or complication from numbing at the dentist? **Yes No**

Needle Phobia? **Yes No** Alcohol Intake? **Yes No** Recreational Drugs/Nicotine? **Yes No**

Have you had previous cosmetic injections? **Yes No**

If yes, what product? Restylane Botox Collagen Juvéderm Radiesse Sculptra Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was the last time you had the injection? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you using Retin A, Hydroquinone (Bleaching Cream), Glycolic Acid, Accutane or any medication that could cause sun sensitivity? **Yes No Skin care products currently being used: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

If you have taken Accutane, when did you last use it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you recently had a peel (chemical, acid, fruit, microdermabrasion)? **Yes No**

Have you had any laser or photo facial treatments? **Yes No** If so,When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a cold sore/herpes virus? **Yes No** If so, When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Could you be pregnant? **Yes No** Are you breast-feeding? **Yes No** PCOS/Hormonal Issues? **Yes No**

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? **Yes No**

Do you have permanent cosmetic tattoos? **Yes No**

If so, where? Eyebrows Eyeliner Lip Liner Beauty Mark Enhancement Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any freckles, moles or skin condition that has caused concern? **Yes No**

Skin Cancer Diagnosis? **Yes No** If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that the preceding medical, personal, and skin history statements are true and correct. I am aware that it is my responsibility to inform the doctor or the nurse of my current medical or health conditions and to update this history with each appointment. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Cancellation Policy:

*In addition, I am aware that a 24-hour cancellation policy exists. If I do not cancel my appointment within the time frame, I agree to pay a missed appointment fee of $100.00.*

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practitioner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Office use:***

Skin Type:

Provider Notes: NP approved:

**Copy to: patient chart**